BQC - 91 – 011

Date: March 11, 1991

To: Home Health Agencies HHA 4

From: Larry Tainter, Director
Bureau of Quality Assurance

Subject: New Interpretations of Federal Home Health Conditions of Participation

The Bureau of Quality Compliance has received some new interpretations of federal home health requirements as a result of questions directed to the federal Health Care Financing Administration (HCFA). This memo will address these new interpretations and provide guidance on how the Bureau will handle these areas.

1. Patient Liability – 42 CFR 484.10(e)

The federal Health Care Financing Administration (HCFA) has interpreted this regulation to require that the agency provide either a list of all of its specific charges for all services and equipment it supplies or a list of all specific charges for the services and equipment it will be providing to a specific patient. Additionally the agency must, to the best of its knowledge, indicate the amount of coverage for these charges from Medicare, Medicaid or other federally funded programs (e.g., Title XX).

Additional information clarifying this area was just received in a letter to HCFA, Region V, from Kathleen Buto, Director, Bureau of Policy Development, HCFA, Baltimore. Ms. Buto states:

> You requested clarification of the regulation at 42 CFR 484.10(e)(1)(ii) and (iii), which require the HHA to advise patients of the charges for services not covered by Medicare and the charges that the individual may have to pay. Specifically, you asked clarification of the extent to which the HHAs are expected to estimate the specific amount of charges.
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> The HHAs are expected to make the best estimate possible of the patient's potential financial liability given the information they have at the time the estimate is made. This estimate should include a specific dollar amount rather than a general discussion of Medicare coverage. Of course, we cannot expect the HHA to anticipate changes in the patient's need for services, the price of needed items, or Medicare coverage that may occur while the patient is under its care. However, the HHA should be expected to use the information available at the time of the disclosure to furnish the patient with a realistic estimate of his or her potential financial liability.

HCFA central office, Baltimore, has given a verbal opinion that this regulation does not require home health agencies to provide liability information for private insurance, although if possible, the agency should provide this information. The Bureau is aware that agencies have been cited for not providing patient liability information for private insurance. If you believe your agency was cited with such a deficiency, please notify the Bureau of the deficiency by the six (6) digit Statement of Deficiency number located in the upper right hand corner. These deficiencies will be reviewed and if appropriate, the deficiency will be withdrawn or modified by removing examples related to private insurance liability.

2. Frequency of Visits – 42 CFR 484.18(a)

HCFA has clarified that orders for care can indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided to home health patients. However, HCFA has indicated to the Bureau that when a range of visits is ordered, the upper limit of the range is to be considered the specific frequency to be provided unless documentation exists in the patient record as to why a lower frequency of visits was provided. HCFA has cited the coverage section of its Home Health Agency Manual as defining the upper limit of a range of visits to be the specific frequency.

Additionally, in response to questions raised regarding the frequency and duration of visits Ms. Buto has also responded in her letter to HCFA, Region V, that:

> As you know, the HHA is obligated to furnish services in a manner consistent with its own policies as well as Medicare and other requirements. In the event that the HHA should choose to accept a patient whose POC requires a specific duration of visits, the HHA is obligated to furnish services consistent with the POC and therefore must provide visits of the required duration.
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> In addition, the HHA is required by the same regulation at section 484.18 to accept patients on the "basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately in the patient's place of residence." If the HHA accepts a patient without the reasonable expectation that it can meet the needs of that patient as required by the POC, then that HHA would not be in compliance with this requirement. This requirement is especially important when one takes into account the requirements of section 484.30(a), which establishes the initial evaluation visit and the initiation of the POC as duties of the registered nurse… This same requirement applies to the reference to staff availability in the POC. An HHA should only admit those patients whose needs can be adequately met by their staff, not those whose needs can only be met when staff is available. If the HHA believes that the physician is ordering care in excess of the patient's needs, then they should express their concerns to the physician.

As with the liability issue, the Bureau of Quality Compliance will review any deficiency, issued prior to this letter, which cited an agency for not meeting the upper limit of a range of visits. Again, deficiencies must be identified by their Statement of Deficiency number. Subsequent to the notice given in this memo, agencies will be expected to meet the upper limit of the range of visits unless specific documentation is provided as to why less frequent visits were provided. Obviously, lack of staff will not be considered a reason for not meeting the upper range of visits.

3. Three hour inservice requirement – 42 CFR 484.36(b)(2)(iii)

Ms. Buto's memo succinctly summarizes what is expected in terms of home health aide inservice for aides utilized by several agencies:

> You also asked for clarification of the regulations at 42 CFR 484.36(b)(2)(iii), which require that "the home health aide must receive at least 3 hours of inservice training per calendar quarter." If the aide is a contract employee of more than one HHA, he or she is not required to receive 3 hours of inservice training from each employer. The agencies may share or coordinate the training of the aide, or the aide may receive his or her inservice training from another organization as allowed by 42 CFR 484.36(b)(3)(i). It is important to note that each HHA is responsible for maintaining documentation which demonstrates that the inservices training requirement has been met, as required by 42 CFR 484.36(b)(5).

If you have questions on these interpretations, please call Allan Stegemann at (608) 266-2055.

LT/ADS/jh 5945a

cc: -HHA Surveyors
-Wisconsin Homecare Organization
-Wis. Assoc. of Homes and Services for the Aging
-Wis. Assoc. of Nsg. Homes
-Wis. Counties Assn.
-Wis. Medical Records Assoc. Consultants Comm.
-Service Employees International Union
-Wis. Coalition for Advocacy
-Comm. on Aging, Extended Care Facilities and HH Care
-George F. MacKenzie
-Jerry Sandlin, HCFA-Region V